"Did You Shoot Anyone?" A Practitioner’s Guide to Combat Veteran Workplace and Classroom Reintegration

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"What the Hell Happened to Terry?" Nothing seems out of the ordinary this day at the California-based health care firm. On the fourth floor, the marketing staff goes about their business as warm autumn sunshine streams through the glass panels that form the building’s exterior walls. A project team casually gaggles around a worktable spread with charts and documents. Suddenly, a voice calls out, "Hey! Look at that!" A large, black military helicopter zooms low across a nearby field, heading toward the building. As employees gather at the glass wall, the chopper seems almost to fill the sky, the droning of its blades rising to a roar. It soars over the building, vanishing toward a nearby military base, leaving a wave of excitement in its wake. As people drift back to work, one of the project team members looks around. "Where's Terry?" Silently, a secretary points to a desk, its chair overturned. There, beneath the desk, hands clasped over his head, crouches Terry. As he sheepishly emerges, a voice from the back of the group mutters, "Jeez, Terry, what the hell happened?"

Since the onset of the Global War on Terror, more than 1.6 million men and women of the United States Armed Forces have deployed to Afghanistan and Iraq. A large percentage of these are Guard (247,695) and Reserve (195,796). Many have experienced two and some even three or four tours of duty in combat zones. As these combat veterans leave the military and return to civilian life, they bring with them the physical and mental consequences of wartime service. While advances in medical care have saved numerous lives on the battlefield, we are still faced with a staggering number of men and women who have sustained serious psychological injuries as a result of combat. One in four soldiers discharged from Operation Enduring Freedom (Afghanistan) and Operation Iraqi Freedom (Iraq) have filed disability claims with the Veterans Administration, over 40,000 of which have been for post-traumatic stress disorder (PTSD) (Meagher, 2007).

America has come a long way from the time when returning Vietnam War veterans were greeted with hostility and suspicion. "Support the Troops" has become everything from a fashion statement to a national mantra. Yet when we move from the general to the specific, when we encounter the returning combat veteran in the workplace or the classroom, when a helmet-clad every soldier in a news magazine becomes a real person sitting behind a desk, what does "support" mean?

This paper proposes that there are practical things managers and educators can do to help combat veterans reintegrate into the workplace and classroom. We’ll begin laying the groundwork with what makes the War on Terror different from previous U.S. conflicts. Next, we’ll consider the psychological stress that can result from combat operations, specifically PTSD. Finally, we’ll examine specific attitudes,
behaviors, and strategies that can help ease the combat veteran’s transition to the civilian work and school environment, presenting some dos and don’ts for managers and educators seeking to support successful veteran reintegration.

A Different Kind of War
“I feel like Bill Murray in the movie Groundhog Day.”

Indiana soldier preparing for a return deployment to Iraq (Bode, 2007)

It seems patently obvious to say that the war on terror is a different kind of war. Every war is distinguishable in such ways as cause, place, technology, and political consequence. Author Ronald Manderscheid (2007) points out three distinctions affecting social reintegration following Iraq and Afghanistan service: duty tour length and pattern; danger level; and disengagement from civilian culture. To that we add two more: uncertainty of duration and the types of casualties the War on Terror brings.

Both Vietnam and Gulf War combatants saw relatively short tours of duty. Most Vietnam tours lasted approximately 12 months, and for most individuals, one tour was all that their service demanded. Gulf War tours lasted no longer than the brief duration of that conflict. Most recently, duty in Bosnia and Kosovo rarely lasted beyond a year. Deployment to Iraq and Afghanistan, in contrast, has extended as long as two years (Manderscheid, 2007). More important, many combatants have served or are serving their second or even third rotation in support of Operation Iraqi Freedom (Iraq) or Operation Enduring Freedom (Afghanistan). While service in the military itself is voluntary, deployment to the combat zone is, in most cases, not a matter of choice. Too, the pattern is unpredictable: entire deployed units may be extended, or individuals may be deployed and have their deployment extended, in either case with short notice, adding significantly to stress.

The character of this war also differs. Vietnam and the Gulf War were largely conventional conflicts. Enemy combatants were readily identifiable (excepting guerilla combatants in Vietnam), and, for the most part, clear distinctions existed between battle zones and safe zones (Manderscheid, 2007). In Afghanistan and Iraq, there are no safe zones, merely areas of greater and lesser degrees of risk. Even the so-called “Green Zone” is under recurring mortar and rocket attack. Soldiers and Marines on patrol are under constant threat from improvised explosive devices (IEDs), snipers, and the grinding tension between terror and tedium. Moreover, many are being asked to undertake new missions tied to stability and reconstruction; in many cases, they’re performing tasks for which they may have received little or no training, although this is improving.

Next, this war is employing a mixed set of volunteers, including a large number of Guard and Reserve forces. While reserve component members have a strong affiliation to their units, their contact is intermittent; they lack the uninterrupted association with the military community experienced by their active duty counterparts. Their strongest affiliation lies with their civilian communities, and their reintegration with this radically separate environment will differ greatly from that of combat veterans returning to a military environment (Manderscheid, 2007). Compounding this, Reservists can be deployed as an entire unit, in small teams or as individuals. Their post-deployment support is often split among their home unit, an affiliated active duty unit, and civilian health care providers, making continuity of care and support a particular challenge.

Another significant difference lies in the uncertainty of this war’s duration. As recently as the 2008 State of the Union Address, the President noted that “They [al Qaeda] are not yet defeated, and we can still expect tough fighting ahead” (Bush, 2008). While he noted that U.S. participation is away from leading and toward partnering and eventual overwatch, the subtext is an indefinite American presence. To the soldier, this translates to more of the same, i.e., the “groundhog day” effect. The Iraq War veteran from Indiana elaborates:

This time around I already know what is going to happen for the next 18 months. The bottom line: My battalion will deploy again, most of us will make it home, some will not . . . . The one thing that motivates me in my current grind is the knowledge that if I survive my next deployment I’ll have the opportunity to start a normal existence again. (Bode, 2007)

In that word, “normal,” lies the most significant difference in the current conflict: injuries that complicate the struggle for normalcy upon return from the combat area. Improvements in vehicle and personal armor, coupled
with advancements in battlefield medicine, mean that soldiers who in prior wars would have died are now surviving, albeit often with debilitating wounds. Moreover, because so many of these injuries involve concussive blasts from IEDs (single and multiple), we are seeing a high proportion of casualties with traumatic brain injury, ranging from mild to severe. Evidence suggests that even mild traumatic brain injury is related to PTSD, indeed, many of the symptoms are indistinguishable (Hoge, McGurk, Thomas, Cox, Engel and Castro, 2008). Yet as we shall see, it doesn’t take concussive blast and traumatic brain injury to produce PTSD.

Nature and Prevalence of Post-Traumatic Stress Disorder

“The physical war is over. The mental war has just begun.”

Iraq War veteran (Pitts, 2005, in Meagher, 2007)

What we today call PTSD has, in fact, been a consequence of combat since earliest recorded history. In his groundbreaking works Achilles in Vietnam: Combat Trauma and the Undoing of Character (Shay, 1995), and Odysseus in America: Combat Trauma and the Trials of Homecoming (Shay, 2002), Department of Veterans Affairs psychiatrist Jonathan Shay explores the psychological trauma induced by prolonged exposure to wartime stress through Homer’s epic poems The Iliad and The Odyssey. Through these accounts of real, albeit ancient, historical events, Shay makes a compelling case that PTSD has been around as long as war itself. During the American Civil War, the condition was termed “irritable heart” or more simply “nostalgia.” World War I brought nomenclature like “shell shock,” “hysteria” or the more clinical “neurasthenia.” During the Second World War, “battle fatigue” was the most frequent name, although “war neurosis” and “exhaustion” were also employed. Vietnam veterans were labeled as suffering from “post-Vietnam syndrome.” It was not until 1980 that the third edition of the American Psychological Association’s Diagnosis and Statistical Manual of Mental Disorders (DSM-III) listed the condition “posttraumatic stress disorder” or PTSD (Coleman, 2006). The current DSM-IV describes PTSD as “the development of characteristic symptoms following exposure to an extreme traumatic stress or involving direct personal experience of an event that involves actual or threatened death or serious injury, or other threat to one’s physical integrity.” True PTSD response “must involve intense fear, helplessness, or horror (APA, 2000, 309.81).

Not every returning Iraq or Afghan War veteran suffers from PTSD. Yet the condition is prevalent enough that it has become the topic of a recent study involving 2,525 soldiers. Results indicate that “more than 40% of soldiers with injuries associated with loss of consciousness met the criteria for PTSD” (Hoge, McGurk, Thomas, Cox, Engel and Castro, 2008). Further, retired Army psychiatrist and consultant to the Secretary of the Army Brigadier General Stephen Xenakis stated that one Army study based on data from questionnaires administered upon return from the combat zone and five or six months later showed that at least 20–25% of returning soldiers experience “severe mental problems” (Xenakis, 2008). Other estimates (Greenwald, 2006) indicate that 30% of returning soldiers will suffer from PTSD (symptoms or diagnosis), rising to 70% for those returning from a second deployment.

Mental health experts in the field of PTSD (Hoag, Castro, Messer, McGurk, et al., 2004) admit that there are wide gaps in understanding the full psychosocial ramifications of combat. Therefore, few longitudinal studies to inform the dialogue surrounding PTSD and the returning combat veteran (Litz, 2007). The Millennium Cohort Study (Ryan, Smith, Smith, Amoroso, Boyko, Gray, et al., 2007) was launched in 2000 in response to health concerns of military members surrounding deployment and other service-connected experiences, to include PTSD. The study enrolled a first panel of 77,047 participants from all branches and components of the U.S Armed Forces. Early findings indicate that of the 40% of the cohort who were on active duty between 2001 and 2006, there was a three-fold increase in PTSD symptoms or diagnosis among those military personnel who reported combat exposure (Smith, 2007).

All this points to a significant proportion returning combat veterans who will enter the workplace or the classroom facing challenges beyond mere culture change. As Dr. Brett T. Litz (2007), Associate Director of the National Center for Post-traumatic Stress Disorder notes:

A new generation of veterans may be at risk for life course disturbances implicated by exposures to war-zone stressors and
adversities... There are initial signs that veterans of the wars in Iraq and Afghanistan are at risk for PTSD, which can be a lifelong challenge for veterans. There is much we do not know about how service members manage and adjust to the enormous and diverse demands and traumas in these new war zones (Litz, 2007).

Faced with this challenge, and hampered by the lack of empirical research, how are managers and educators to foster successful réintégration of the returning veterans? Our approach is to listen to the voices of the veterans themselves.

**Recommendations to Managers and Faculty**

"I wasn’t scared to go to Iraq. I wasn’t really even scared about what would happen when I lost my legs. You want to know what I was really scared of? I was absolutely terrified to go home."

U.S. Army Corporal, Ohio, Wounded Warrior

Even veterans who do not suffer from PTSD or traumatic brain injury still experience some disorientation upon re-entering the civilian workforce and classroom. Many are unsure how they will be received outside the military community; the memories of the treatment of Vietnam veterans linger still. Journalist Kristin Henderson, author of *While They’re at War* and spouse of a military chaplain who served in Iraq and Afghanistan, reminds us that

This problem of veterans who’re returning and having trouble reintegrating — it’s not just a problem for them and their families. It’s a community problem, particularly as they detach from the military, or if they’re National Guard or Reserve, they demobilize. They are leaving the military community, and they’re out there” — they’re your neighbors... They’re encountering teachers, they’re encountering police officers, and these folks may not know where the veterans and their families are coming from when they first encounter them if they’re struggling (Henderson, 2008).

In talking and working with veterans of the war on terror on a daily basis for more than five years, we have seen several themes emerge. From those, we have distilled a number of specific suggestions to facilitate the veterans transitions from war zone to work zone.

**Curb your anxiety.** Many managers and educators, while eager to support those who have served their country, harbor anxieties about how to deal with someone whose last professional experience involved carrying a weapon in a hostile environment. One professor explained his concerns during a recent public radio broadcast:

This term I have two Iraq vets who are in their 30s, both are hardworking, highly stressed, mentally fragile. Last year I had an Iraq vet in class. He demonstrated an unbelievable level of stress. In an effort to help him, I gathered some background information. Can you imagine how I felt when I learned this very unstable individual earned a certificate of merit for his marksmanship skills? I felt as though I had a target on my back the entire term. What if he were dissatisfied with the grade he earned? I imagine that situations like this will increase in years to come. The university cannot do anything until the individual makes a threat; by then it will be too late (Unidentified caller, 2007).

No empirical evidence suggests that returning combat veterans are predisposed to dispatch professors or bosses with whom they disagree. Virtually every military person who deploys (with certain exceptions: chaplains, for example) is proficient (certified) in one or more weapons. This does not make them any more likely to respond with violence than any other person in the workplace or classroom. Indeed, the two most recent high-profile campus shootings were by civilians.

Xenakis suggests that “the faculty member... can really help by not feeling alarmed... And there are ways of reaching out to them and there [are] ways of supporting them” (2008). Like the Ohio veteran just quoted, many fear the reaction of family, friends, co-workers and classmates to someone who has seen and perhaps participated in the violence that is warfare. Managers and teachers who behave toward the veteran much as they behave toward other workers or students can do much to create an atmosphere of normalcy for the veteran.

*It’s ok to say thanks.* It’s not a good idea to let
wartime service become the elephant in the living room. While few veterans want coworkers and classmates to make a big deal out of their wartime service, pretending it didn’t happen is detrimental to honest communication. After all, they weren’t vacationing in the Bahamas! But don’t fuss. Soldiers are traditionally modest about public praise. However, phrases like, “Thanks for what you did over there,” “We really appreciate your service,” and “It’s great to have you home” are ways to let the veteran know that his or her efforts and personal sacrifice are remembered and valued — regardless of the speaker’s political viewpoint. Speaking of political viewpoints:

_Curb your politics._ Resist the temptation to ask the returning veteran, “So, do you think we ought to be in Iraq? What do you think of Bush?” Most military members keep their politics to themselves and few appreciate being put in a position to debate the issue. Moreover, the reasons many people enlisted in the military and went to war have little to do with political ideology. “I don’t pay much attention to the politicians or what I see on TV,” confided the Ohio corporal. “I was there for my country, because of 9-11. And for my buddies.” Remember that many have lost friends to the war on terror, and in their minds, this is far more than an academic discussion.

_Channel your curiosity._ Ninety percent of adult Americans have not served in the military (U.S. Census Bureau, 2006). So it’s natural that people may feel curious about what the wartime experience is like. Military members understand this, and most are willing to discuss their service experiences in general. However, for a recently returned wartime veteran, some topics may be difficult or painful. While this seems intuitive, it’s surprising how many people ask things like, “Did any see anyone die?” “Were you scared?” or the ubiquitous “Did you shoot anyone?” Questions aren’t prohibited; it just means that some sensitivity is in order. First, let the individual set the tone; for instance,

“It’s great to have you home” — welcome back.”
“Thanks — it’s good to be home.”
“So how was it over there?”

If the response is something like, “Pretty tough” or “Worse than here,” followed by silence, chances are that’s all the person wants to say. “People are pretty inquisitive,” explained a wounded Iraq veteran from Colorado who, now recovering, is newly employed. “General questions are OK, like asking what the guy did in the Army. People are proud of their accomplishments. But,” he cautions, “specific questions, like ‘Did you hurt anyone?’ — those could target certain memories.” Sometimes the question elicits tentative conversation or even a burst of war stories. The father of one Iraq War veteran suffering from both traumatic brain injury and PTSD suggests looking for signals that questions may be welcome. “My son had all his medals framed and hung them in his cubicle at work. When his boss asked me, ‘What should I say to him?’ I replied, ‘Ask him about his medals.’” Another veteran shares this advice:

By all means, ask. It helps if you show genuine interest in the person’s experience and really listen. Questions should be open, general. A gentle approach is always a good idea, and focus on hearing versus telling. And don’t take it personally if the person doesn’t want to talk about it (Personal interview, 2008, name withheld).

_It’s not about you._ Some people become offended or feel rejected when the returning veteran doesn’t want to talk about his or her experiences. It’s important to know that this reluctance to share is rarely personally directed at the questioner. Minnesota Army National Guard chaplain Major John Morris explains:

Co-workers should brace for strong indifference from veterans … an attitude along the lines of “I’ve been at the center of world events, and everything I’ve been doing is more important than what you’ve been doing.” On their side, co-workers can stop asking the kind of troubling questions veterans now get. You do not want to ask, ‘Did you kill anybody?’ Morris said. “Or sometimes people ask, ‘Do you think we should be there? Do you think we’re winning?’ Then they use that to go into their own politics, which is not appreciated. Instead, Morris suggests showing interest with open-ended questions, so veterans can go only as far as they’re comfortable, questions such as: “What was your experience like?” “How was it coming home?” “What would you like to share about your time in Iraq?” (Cummins, 2006)
Closely tied to the ambivalence related to the nature of the wartime experience is the combat veteran’s sense that only other veterans can truly understand their experience. Some veterans are reluctant to speak with anyone who wasn’t “in the AOR (Area of Responsibility),” while others will open up to those who wear or have worn the uniform. A study examining the effect of combat experience on personality development sums up as follows:

This sense of security, safety, and comradeship does not fit well with life in the real world. This is due to civil life being less rigid and well defined, and there being little impetus to develop life-or-death comradeships. And the vast majority, without combat experience, cannot empathize with these emotions. [The “Warrior Ethic”] has no place and few analogies in civil life . . .

(Rutolo, 1993)

Respect their privacy. Managers and teachers may find themselves wondering, “Does this guy or gal have PTSD? How will I know?” Frankly, you may not, any more than you would know whether someone in your workplace or classroom suffers from diabetes or depression. However, you may observe signs of stress and tension that lead you to suspect that some form of combat-related stress is still present. These include:

- Trouble concentrating for long periods
- Discomfort with silence
- Unease in large gatherings
- Increased absenteeism
- Decreased ability to function at work
- Disturbances in relationships with co-workers and classmates

Remember, too, PTSD often becomes more severe in months following departure from the combat zone (Litz, 2007). One veteran who returned to college described it this way:

You’d freak out. Two hundred people around you when you’re used to just — if you’re just fresh out of war or something, or even been out for just six, seven months, you’re still going to have the paranoia of having so many people around you . . . It’s like, wow, you know, my heart starts going. I start looking around, and that’s when I started walking around and just looking around and seeing if everything’s okay. And it’s just — people just, they look at you and it’s like, wow, what’s wrong with that guy? (Turner, M., 2008)

Compounding stress reactions is the impact of military culture on veterans suffering from PTSD. In War and Gender, author Joshua Goldstein explains, “In World War I, and other cases, shell shock was treated as tantamount to a failure of manliness,” because “‘shame is the glue that holds the man-making process together” (Goldstein, 2001). So it’s no surprise that a 2006 study of 1,767 Army and Marine war on terror veterans found that less than 50% of those who screened positive for a mental health problem sought help. Reasons cited included fear of being treated differently; being seen as weak; losing the confidence of unit members; and fear of harming their career (U.S. Army, 2006).

In light of this, managers’ and professors’ best course of action is to refrain from questioning the veteran about specific health conditions. Instead, a private inquiry, “I noticed you seem a bit tense. Is everything all right?” or “Is there anything I can do for you?” is the best way to express your concern and open the door for dialogue. But essentially, we recommend following the advice of retired FBI supervisory agent and workplace violence expert Gene Rugala, who says, “I wouldn’t treat veterans any differently, other than knowing what they’ve gone through and being more sensitive to some of those issues that develop” (Collett, 2008).

Know your resources. Local Employee Assistance Programs are often a useful place to start. As the number of returning veterans grow, so too does program awareness and experience. Depending on location, transition support for reintegrating veterans may be available through the Veterans Administration. Support may be readily available through the company health care plan or school health care center. There may be local community resources that support stress management. In addition, these Web sites are useful for those wanting to learn more about veteran issues and support:

- Post-deployment health care: http://www.pdhealth.mil/
- The National Center for Post-traumatic Stress Disorder: http://www.ncptsd.va.gov/ncmain/index.jsp
- Military Benefits: http://www.military.com/
Finding the New Normal

"War stories end when the battle is over or when the soldier comes home. In real life, there are no moments amid smoldering hilltops for tranquil introspection. When the war is over, you pick up your gear, walk down the hill and back into the world."

Iraq War Veteran (Crawford, 2005)

Since the earliest record of warfare, the returning warrior has struggled to rejoin the society left behind. It has never been an easy transition, but the war on terror brings new and unanticipated complications for the combat veteran. New technology means survival for those who would have died in prior wars, yet that very survival is fraught with challenges we are only now learning to address. Understanding what distinguishes this war as it pertains to the returning combat veteran; comprehending the ramifications of traumatic brain injury and PTSD; and seeking to identify the attitudes and behaviors that ease the disorientation of return is one service that managers and educators can offer to those who have served their country under the harshest conditions.

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Note: The views expressed in this article are those of the authors and do not reflect the official policy or position of the National Defense University, the Department of Defense, or the U.S. Government.

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Appendix

Criteria for Posttraumatic Stress Disorder from DSM-IV**

(Source: Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition, Text Revision. Copyright 2000 American Psychiatric Association)

Diagnostic criteria for 309.81 Posttraumatic Stress Disorder

A. The person has been exposed to a traumatic event in which both of the following were present:
   1) the person experienced, witnessed, or was confronted with an event or events that involved actual or threatened death or serious injury, or a threat to the physical integrity of self or others
   2) the person's response involved intense fear, helplessness, or horror. Note: In children, this may be expressed instead by disorganized or agitated behavior

B. The traumatic event is persistently reexperienced in one (or more) of the following ways:
   1) recurrent and intrusive distressing recollections of the event, including images, thoughts, or perceptions. Note: In young children, repetitive play may occur in which themes or aspects of the trauma are expressed.
   2) recurrent distressing dreams of the event. Note: In children, there may be frightening dreams without recognizable content.
   3) acting or feeling as if the traumatic event were recurring (includes a sense of reliving the experience, illusions, hallucinations, and dissociative flashback episodes, including those that occur on awakening or when intoxicated). Note: In young children, trauma-specific reenactment may occur.
   4) intense psychological distress at exposure to internal or external cues that symbolize or resemble an aspect of the traumatic event
   5) physiological reactivity on exposure to internal or external cues that symbolize or resemble an aspect of the traumatic event

C. Persistent avoidance of stimuli associated with the trauma and numbing of general responsiveness (not present before the trauma), as indicated by three (or more) of the following:
   1) efforts to avoid thoughts, feelings, or conversations associated with the trauma
   2) efforts to avoid activities, places, or people that arouse recollections of the trauma
   3) inability to recall an important aspect of the trauma
   4) markedly diminished interest or participation in significant activities
   5) feeling of detachment or estrangement from others
   6) restricted range of affect (e.g., unable to have loving feelings)
   7) sense of a foreshortened future (e.g., does not expect to have a career, marriage, children, or a normal life span)

D. Persistent symptoms of increased arousal (not present before the trauma), as indicated by two (or more) of the following:
   1) difficulty falling or staying asleep
   2) irritability or outbursts of anger
   3) difficulty concentrating
   4) hypervigilance
   5) exaggerated startle response

E. Duration of the disturbance (symptoms in Criteria B, C, and D) is more than 1 month.

F. The disturbance causes clinically significant distress or impairment in social, occupational, or other important areas of functioning.

** The criteria provided here are for informational purposes only. The diagnosis of PTSD should be made only in consultation with a clinician who by special training is competent to diagnose this condition.
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